PATIENT REGISTRATION

Date:

Child's Name: DOB: ☐ Male ☐ Female

Child's Address: Home Phone:

City: State: Zip:

Emergency Phone # ***(other than parents)*** Name: Relation:

Any special health conditions? ☐YES ☐NO (if yes, please specify)

Responsible Party - Primary Insured's Information

Name: Relationship to patient:

Address:

City: State: Zip:

D.O.B. Driver's License #: Social Security#:

Home Phone: Cell Phone: Which phone# is Primary? ☐ Home ☐ Cell

Occupation: Email Address:

Employer: Work Phone:

Employer Address:

City: State: Zip:

Insurance Carrier: Phone:

Group# ID#

Other Parent

Name: Relationship to patient:

Address:

City: State: Zip:

D.O.B. Driver's License #: Social Security#

Home Phone: Cell Phone: Which phone# is Primary? ☐ Home ☐ Cell

Occupation: Email Address:

Employer: Work Phone:

Employer Address:

City: State: Zip:

Insurance Carrier: Phone:

Group# ID#

Referred by: Phone:

Address: City: State: Zip:

FRISCO PEDIATRICS, P.A.

Kathleen D. Stokes, M.D. *Lauren A. Reeves, PA-C*

OFFICE POLICY

All patients:

- Patients are seen by appointment only. Ill children will be scheduled as appointments become available.
- All patients who are 15 minutes late or later may be asked to reschedule their appointments so that we do not keep our other scheduled patients waiting.
- Payment is due when services are rendered unless prior arrangements have been made.
- Insurance and Medicaid patients have **30 days** to add a newborn child to Insurance or Medicaid coverage.
- A copy of your Insurance card or Medicaid eligibility form is required for your initial visit in order for this office to file claims. Thereafter, you must bring your **child's current** insurance card or Medicaid eligibility form to every visit in order for the child to be seen.
- Antibiotics are not prescribed or refilled without a physician assessment.
- Referrals and authorizations are not given without a physician assessment.
- If a referral is needed for a specialist, at least a one week notice is required by this office in order to process it, unless it is deemed an emergency by the physician.
- There will be a $30 return check fee on all returned checks.
- A fee of $25 will be charged for appointments missed if not cancelled 24 hours in advance.
- **Telephone Calls:**
  Frisco Pediatrics, P.A. encourages parents to use common sense and educational resources before making telephone calls to this office, especially after hours. Please do not hesitate to call for a true emergency. However, excessive telephone calls may become subject to charge.
- **Caller ID Alert!!** If you are using the "ANONYMOUS" option you will not receive calls from this office generated from the back lines or from private residences of the individuals who are on call. If you have placed a call to the office and are awaiting a return call, you must turn off the "ANONYMOUS" option in order to receive the call. Failure to do so will result in delay of communication.
- You have authorized us to utilize the phone numbers supplied on the Patient Registration Form for communication with you.

I understand the above policies and agree to abide by them.

Parent/Guardian Signature **Date**

Release and Assignment

I authorize Kathleen D. Stokes, M.D., and/or her member physicians to release and furnish on a confidential and strict need to know basis all medical and financial data related to the care of the above named patient that is necessary to facilitate payment by third parties for services rendered by Physician, or to assist with, or aid in medical outcomes evaluation purposes. Such information may be released to insurance companies, HMOs and PPOs, IPAs, Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions.

I authorize the personnel of **Frisco Pediatrics, P.A.,** to render medical or surgical treatment to my dependent child now and anytime the child seeks medical attention, even in my absence.

I further authorize and request my insurance company to pay directly to the above named entity the amount due for treatment/services to the patient named below. I understand that all fees incurred in the treatment of this patient by **Kathleen D. Stokes, M.D.,** and/or her member physicians are ultimately my responsibility.

Patient Name **Responsible Party/Parent Signature** **Relationship to Child** **Date**

Witness (Frisco Pediatrics, P.A., Employee) **Date**

FAMILY HISTORY

PARENTS	AGE	HEALTH STATUS	OCCUPATION	MARITAL STATUS	HIGHEST GRADE COMPLETED

SIBLINGS NAME	D.O.B	AGE	HEALTH STATUS	SEX	FULL	HALF	STEP

FAMILY HEALTH PROBLEMS: IDENTIFY PROBLEM AND RELATIONSHIP TO CHILD

DESCRIPTION	PROBLEM	RELATIONSHIP TO CHILD & AGE
SKIN (Dermatitis, Birthmarks, etc)		
EYE, EAR, NOSE, THROAT(Visual, Hearing, Infections, Allergies, Cleft Lip)		
LUNGS,(Asthma, Tuberculosis, Reactive Airways Disease, Emphysema)		
IMMUNOLOGIC(Receiving Chemotherapy or Steroids, AIDS)		
HEART(Heart Disease, Stroke, High Blood Pressure, High Cholesterol)		
BLOOD DISORDERS(Anemia, Sickle Cell Disease, Hemophilia, Leukemia)		
STOMACH(Ulcers, Pyloric Stenosis, Liver Disease, Diarrhea, Constipation)		
KIDNEY(Urinary Tract Infections, Renal Faliure)		
ENDOCRINE(Thyroid Disease, Diabetes)		
BONE/MUSCLE(Dislocated Hips, Arthritis, Scoliosis)		
NERVOUS(Headaches, Seizures, Learning Problems, Mental Illness, Mental Retardation)		
OTHER(Cancer, Obesity, Cystic Fibrosis, Birth Defects, Alcoholism)		

PRESCREENING LEAD QUESTIONAIRE

Date:_____

Patient Name:_____D.O.B._____

1. Does anyone living in your house work at a place or have a hobby that involves these things? **Yes** **No**

   (circle all that apply)

radiator repair	housing renovation	stained glass w/lead solder
lead industry	smelting	bridge/tunnel/elevated hwy construction
welding	chemical preparation	burning lead painted wood
battery manufacture	making pottery	casting ammunition/fishing wts/toy soldiers
battery repair	auto repair	industrial machinery & equipment
valve/pipe fittings	refinishing furniture	going to fire range
brass/copper foundry		

2. Does your child eat or chew on things like paint chips or dirt? Yes No
3. Does your child live in an old house with peeling or chipping paint? Yes No
4. Does your child often visit someone who lives in an old house with peeling or chipping paint? Yes No
5. Do you live in a house that was built before 1978? Yes No
6. Does your child visit or live in a house that is going through remodeling or went through remodeling recently? Yes No
7. Does your child live in or often visit a house that is being painted or having the paint on it scraped or sanded? Yes No
8. Have any other members of the family had high blood levels of lead? Yes No
9. Do you give your child, or have you ever given your child any of these products from another country:
   - *MEDICINES like greta or azarcon for empacho, alarcon, alkohl, bali goli, coral, ghasard liga, pay-loo-ah or rueda? Yes No
   - *NATURAL VITAMINS OR SUPPLEMENTS? Yes No
   - *COSMETICS like somma or kohl? Yes No
10. Does your family live near any of these? **(circle the ones that apply)** Yes No

smelter	place where batteries are manufactured
hazardous waste site	site of house renovation
lead industry	

11. Does your child play where cars are abandoned or repaired? Yes No
12. Is pottery used to cook or store your food? Yes No
13. Does your child eat foreign food? Yes No

_____

Parent/Guardian Signature Date